EYE EXAMINATION SHEET

6-4-04

TO: (Service Physician)	FROM: (Requesting Ward. Med. Fac. Phys.)	Date of Request:
Bradford	V. Anderson -	~~3-29-04~~

Reason For Request: (Complaints and Finding)

Past History

Old Rx

Signature: J. Scott lpn

Type of Consult ☐Emergency ☐Routine

CONSULTATION REPORT

Subjective: OD 20/25 OS 20/25

OPHTH: 20% c/d / wnl

New Rx: OD OS

Seg. Ht. (24)

Ext:
Date Dispensed & Initials:

Seg. Type: Plano -075 x095 / +175
Plano -075 085 / add 59/56

IDP & Time:

Frame: 48/18/145
Size:
Color:

6/4/04
OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	I D No.
Reed	Ernest		48	W/M	119140

F-65 Rev. (1-95)

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Easterling Correctional Facility 0032
Site Phone #: 334-397-3126
Site Fax #: 334-397-3129
Will there be a change? ☐ Yes ☐ No
Sex: ☑ Male ☐ Female
Patient Name (Last, First): Reed, Earnest
Address: 111911C
Inmate #: 111911H
DC Number: 424.74.3880
Date: 02.18.04
Date of Birth: 11.23.55
PHS Eligibility Date: 12.15.2003
Projected Release Date: 02.18.2008

Responsible party: ☐ Inmate ☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid)

CLINICAL DATA

Requesting Provider: Victoria W Anderson
Facility Medical Director Signature and Date:
☐ Service meets criteria for "approval via protocol"

Please a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Consult (CN)
☐ Routine ☐ Urgent
Estimated Date of Service (mm/dd/yy): ___/___/___
(This starts the approval window for the "open authorization period")
Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: _____ ☐ Other: _____
Specialist referred to: general surgeon
Type of Consultation, Treatment, Procedure or Surgery:
hernia repair

History of illness/injury/symptoms with Date of Onset:
6 yrs ago w/ ventral hernia since 8 mos, getting bigger

Results of a complete directed physical examination:
6"x4" incl ventral hernia and midline scar

Previous treatment and response (including medications):
none

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.
☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:
☐ Alternative treatment plan (explain here):
☐ More Information Requested: (See Attached)
☐ Specialist with appropriate credentials
☐ Other Service Recommended and Authorized
Trial of Umbilical hernia repair?
Date authorized: ___/___/___
Regional Medical Director signature, date, and printed name:

Do not write below this line. Reference Number and Corporate Data Entry ONLY.
Auth Type:
Med Class:
Auth #:

UM Referral review form 2-08-2004

FAXED 8:20-04 (8:20 KW)

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
Easterling Correctional Facility #835	Reed, Earnest	02.18.04
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-397-3128	~~111914C~~	11.23.55
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-397-3128	111914	12.15.2003
Will there be a charge? ☐ Yes ☐ No / **Sex** ☑ Male ☐ Female	**SS Number** 424-74-3880	**Potential Release Date: (mm/dd/yy)** 02.18.20028

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):_____

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Victoria W Anderson

Facility Medical Director Signaure and Date:

Victoria W Anderson

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:

48 y.o. WM c ventral hernia since 8 mos, getting bigger

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Results of a complaint directed physical examination:

6"x4" inch ventral hernia and midline scar

Specialist referred to: general surgeon

Previous treatment and response (including medications):

none

Type of Consultation, Treatment, Procedure or Surgery:

hernia repair

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

*****For security and safety, please do not inform patient of possible follow-up appointments*****

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

Date resubmitted: __/__/__

☐ Resubmitted with requested information.

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

LabCorp®

Specimen #	Ord	Src	Received	Rpt
269-397-0123-0	S	MS	Final	Pg 1

Coll Time 07:30

Additional Information

CD- 516522933606

Clinical Information DOB: 11/23/55 Fasting: Y

Patient Name	Sex	Age (Yr/Mos)
REED, ERNEST	M	049/10

Physician ID: DARBOURE

Patient ID: 111914

Account: Easterling Corr. Facility 01400585
Prison Health Services
200 Wallace Dr. 01
Clio AL 36017-0010
334-397-4471
PROV:

Patient Address

Date Collected	Date Entered	Date Reported	
09/26/05	09/26/05	09/27/05	5327

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CMP12+LP+TP+TSH+6AC+CBC/D/Plt					
Chemistries					M
Glucose, Serum	93		mg/dL	65 - 99	M
Uric Acid, Serum	5.7		mg/dL	2.4 - 8.2	M
BUN	11		mg/dL	5 - 26	M
Creatinine, Serum	1.0		mg/dL	0.5 - 1.5	M
BUN/Creatinine Ratio	11			8 - 27	
Sodium, Serum	140		mmol/L	135 - 148	M
Potassium, Serum	4.1		mmol/L	3.5 - 5.5	M
Chloride, Serum	106		mmol/L	96 - 109	M
Calcium, Serum	9.3		mg/dL	8.5 - 10.6	M
Phosphorus, Serum	3.3		mg/dL	2.5 - 4.5	M
Protein, Total, Serum	6.4		g/dL	6.0 - 8.5	M
Albumin, Serum	3.9		g/dL	3.5 - 5.5	M
Globulin, Total	2.5		g/dL	1.5 - 4.5	
A/G Ratio	1.6			1.1 - 2.5	
Bilirubin, Total	1.7	High	mg/dL	0.1 - 1.2	M
Alkaline Phosphatase, Serum	74		IU/L	25 - 150	M
LDH	183		IU/L	100 - 250	M
AST (SGOT)	23		IU/L	0 - 40	M
ALT (SGPT)	16		IU/L	0 - 55	M
GGT	12		IU/L	0 - 65	M
Iron, Serum	142		ug/dL	40 - 155	M
					M
Lipids					M
Cholesterol, Total	168		mg/dL	100 - 199	M
Triglycerides	68		mg/dL	0 - 149	M
HDL Cholesterol	66	High	mg/dL	40 - 59	M
Comment					M
HDL cholesterol values >59 mg/dL are associated with reduced cardiac risk.					
VLDL Cholesterol Cal	14		mg/dL	5 - 40	
LDL Cholesterol Calc	88		mg/dL	0 - 99	
T. Chol/HDL Ratio	2.5		ratio units	0.0 - 5.0	
Estimated CHD Risk	< 0.5		times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

FINAL REPORT

LabCorp® V 1.21

Requisition	Ord	Status	Report Status	
269-397-0123-0	S	MB	Final	Pg 2

Coll Time 07:50 Additional Information

CD- 516522956O6

Clinical Information DOB: 11/23/55 Fasting: Y

Patient Name	Sex	Age (Yr/Mos)
REED, ERNEST	M	049/10

Physician ID: DARBOURE | Patient ID: 111914

Patient Address

Account Easterling Corr. Facility 0148885
Prison Health Services
200 Wallace Dr. 01
Clio AL 36017-0010
334-397-4471
PROV:

Date Collected	Date Entered	Date Reported	
09/26/05	09/26/05	09/27/05	5327

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Thyroid					M
TSH	1.352		uIU/mL	0.350 - 5.500	M
Thyroxine (T4)	7.1		ug/dL	4.5 - 12.0	M
T3 Uptake	32		%	24 - 39	M
Free Thyroxine Index	2.3			1.2 - 4.9	M
CBC, Platelet Ct, and Diff					M
White Blood Cell(WBC)Count	9.1		x10E3/uL	4.0 - 10.5	M
Red Blood Cell (RBC) Count	4.95		x10E6/uL	4.10 - 5.60	M
Hemoglobin	15.3		g/dL	12.5 - 17.0	M
Hematocrit	44.0		%	36.0 - 50.0	M
MCV	89		fL	80 - 98	M
MCH	31.0		pg	27.0 - 34.0	M
MCHC	34.8		g/dL	32.0 - 36.0	M
RDW	13.5		%	11.7 - 15.0	M
Platelets	230		x10E3/uL	140 - 415	M
Neutrophils	71		%	40 - 74	M
Lymphs	20		%	14 - 46	M
Monocytes	6		%	4 - 13	M
Eos	2		%	0 - 7	M
Basos	1		%	0 - 3	M
Neutrophils (Absolute)	6.5		x10E3/uL	1.6 - 7.8	M
Lymphs (Absolute)	1.8		x10E3/uL	0.7 - 4.5	M
Monocytes(Absolute)	0.5		x10E3/uL	0.1 - 1.0	M
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	M
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	M

Lab: MB LabCorp Birmingham Director: John Elgin, MD
1801 First Avenue South, Birmingham, AL 35233
For inquires, the physician may contact: Branch: 334-792-0902 Lab: 205-581-350

LAST PAGE OF REPORT

9/28/05

FINAL REPORT

LabCorp®

Specimen #	Type	Print	Report Status	

Additional Information

Patient Name	Sex	Age (Yr/Mos)

Patient Address

Date Collected	Date Entered	Date Reported	

Clinical Information

Physician ID	Patient ID	

Account

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

not fasting

IF

REPORT

LabCorp®

Specimen #	Type	Print	Report Status	

Additional Information

Clinical Information

Physician ID	Patient ID	

Account

Patient Name	Sex	Age (Yr/Mos)

Patient Address

Date Collected	Date Entered	Date Reported	

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

REPORT

5B-02

ALABAMA DEPARTMENT OF CORRECTIONS N.S. 2-21-05 SEG

Name: Reed, Gerry

RADIOLOGY SERVICES REQUEST AND REPORT

State ID No.: 123606

DOB 7-15-57

INSTITUTION: Elmore

Race: W Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Darby	2-18-05		✓		

HISTORY/DIAGNOSIS:

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OS CALCIS (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	TIBIA/FIBULA
COCCYX	JOINTS	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	LYTOMA
✓ FACIAL BONES X	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

Reed

REPORT:

FACIAL BONES: Water's and lateral views of the facial bones show no evidence of fracture. If symptoms persist and fracture involving the nasal bones, orbits, zygomatic arches or mandible is suspected, specific views of those structures would be recommended.

D &.T: 02-23-05 Howard P. Schiele, M.D./rr Board Certified Radiologist (Signature on file)

2/24/05

X-RAY TECHNOLOGIST'S NAME (PRINT) X-RAY TECHNOLOGIST'S SIGNATURE DATE, TIME EXAM PERFORMED 2-22-05

LabCorp®

Specimen #	Type	Prim	Report Status		
020-397-0178-0	S	Mb	FINAL	PG 2	03 1

TIME 1230 Additional Information

DOB: 11/23/55

CD- 51640439266

Patient Name	Sex	Age (Yr/Mos)
REED, EARNEST		049/01

Patient Address

Date Collected	Date Entered	Date Reported	
01/20/05	01/20/05	01/22/05	3539

Clinical Information 01/22/05 09:15 ET

Physician ID	Patient ID
DARBOURE DARBOURE	111914

Account

Easterling Corr. Facility 0148885
Prison Health Services 01
200 Wallace Dr. 01
Clio , AL 36017-0010
334-397-4471 ALN

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
TSH	1.327		uIU/mL	0.350 - 5.500	
Thyroxine (T4)	7.3		ug/dL	4.5 - 12.0	
T3 Uptake	31		%	24 - 39	
Free Thyroxine Index	2.3			1.2 - 4.9	
CBC, Platelet Ct, and Diff					
White Blood Cell (WBC) Count	6.3		x10E3/uL	4.0 - 10.5	
Red Blood Cell (RBC) Count	5.02		x10E6/uL	3.80 - 5.60	
Hemoglobin	15.2		g/dL	11.5 - 17.0	
Hematocrit	43.3		%	34.0 - 50.0	
MCV	86		fL	80 - 98	
MCH	30.3		pg	27.0 - 34.0	
MCHC	35.2		g/dL	32.0 - 36.0	
RDW	12.7		%	11.7 - 15.0	
Platelets	230		x10E3/uL	140 - 415	
Neutrophils	60		%	40 - 74	
Lymphs	32		%	14 - 46	
Monocytes	6		%	4 - 13	
Eos	2		%	0 - 7	
Basos	0		%	0 - 3	
Neutrophils (Absolute)	3.8		x10E3/uL	1.8 - 7.8	
Lymphs (Absolute)	2.0		x10E3/uL	0.7 - 4.5	
Monocytes(Absolute)	0.4		x10E3/uL	0.1 - 1.0	
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	

LAB: MB LabCorp Birmingham DIRECTOR: John Elgin, MD
1801 First Avenue South Birmingham, AL 35233-0000

FOR INQUIRIES, THE PHYSICIAN MAY CONTACT: BRANCH: 334-792-0902 LAB: 205-581-35
LAST PAGE OF REPORT

LabCorp®

Specimen #	Type	Prim	Report Status		
020-397-0178-0	S	MB	FINAL	PG	1

03 1

TIME 1230 Additional Information

DOB: 11/23/55

CD- 51640439266

Patient Name: REED, EARNEST | Sex: | Age (Yr/Mos): 049/01

Patient Address:

Date Collected	Date Entered	Date Reported	
01/20/05	01/20/05	01/22/05	3539

Clinical Information 01/22/05 09:15 E

Physician ID: DARBOURE DARBOURE | Patient ID: 111914

Account

Easterling Corr. Facility 014888
Prison Health Services 01
200 Wallace Dr. 01
Clio , AL 36017-0010
334-397-4471 ALN

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CMP12+LP+TP+TSH+6AC+CBC/D/Plt					
Chemistries					
Glucose, Serum	143	H	mg/dL	65 - 99	
Uric Acid, Serum	5.4		mg/dL	2.4 - 8.2	
BUN	21		mg/dL	5 - 26	
Creatinine, Serum	0.9		mg/dL	0.5 - 1.5	
BUN/Creatinine Ratio	23			8 - 27	
Sodium, Serum	141		mmol/L	135 - 148	
Potassium, Serum	3.6		mmol/L	3.5 - 5.5	
Chloride, Serum	105		mmol/L	96 - 109	
Calcium, Serum	9.4		mg/dL	8.5 - 10.6	
Phosphorus, Serum	3.8		mg/dL	2.5 - 4.5	
Protein, Total, Serum	6.9		g/dL	6.0 - 8.5	
Albumin, Serum	4.1		g/dL	3.5 - 5.5	
Globulin, Total	2.8		g/dL	1.5 - 4.5	
A/G Ratio	1.5			1.1 - 2.5	
Bilirubin, Total	1.3	H	mg/dL	0.1 - 1.2	
Alkaline Phosphatase, Serum	93		IU/L	25 - 150	
LDH	160		IU/L	100 - 250	
AST (SGOT)	22		IU/L	0 - 40	
ALT (SGPT)	22		IU/L	0 - 40	
GGT	18		IU/L	0 - 65	
Iron, Serum	98		ug/dL	35 - 155	
Lipids					
Cholesterol, Total	177		mg/dL	100 - 199	
Triglycerides	178	H	mg/dL	0 - 149	
HDL Cholesterol	59		mg/dL	40 - 59	
VLDL Cholesterol Cal	36		mg/dL	5 - 40	
LDL Cholesterol Calc	82		mg/dL	0 - 99	
T. Chol/HDL Ratio	3.0		ratio units	0.0 - 5.0	
Estimated CHD Risk				0.0 - 1.0	

CHD Risk cannot be given without patient's sex.

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

Thyroid

111914 01/12/2005 08:50:22 AM Reed,Earnest

49 years Race: W 210 lbs BP:140/84

Rx:
Dx:

Dept:
Room:
Oper:

Rate	68	. Normal sinus rhythm, rate 68	Normal P axis, PR, rate & rhythm
PR	171	. Vertical axis, unusual for age	QRS axis 81 to 90 & age > 40
QRSD	85	. Nonspecific Anterolateral T abnormalities	T neg, T/QRS ratio <.07 I,L,V2-V6
QT	342		
QTc	364		

--AXIS--

P	46
QRS	81
T	56

1/12/05

Requested by:

- BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW